Decline in youth smoking slows A 900-page report from the US Surgeon General has found that the steady decline in smoking in young people has begun to slow. The report stops short of claiming that tobacco manufacturers are advertising to children, but does say that "the evidence is suggestive". Every day more than 1000 US children younger than 18 years become daily smokers.

Access to pain relief The Nigerian Ministry of Health is collaborating with the Global Access to Pain Relief Initiative to make essential pain medicines available in Nigeria for the first time in 2 years. The emergency provision of morphine powder is an important first step to providing relief for the approximately 177 000 Nigerians who die from cancer or HIV every year.

Organ donation in China China's Deputy Minister of Health has announced the extension of a pilot organ donation programme to the rest of the nation within the year. This "ethical and sustainable" transplantation system, which allows organ donation after cardiac death, is hoped to enable more life-saving transplant surgery and help to curb the trade in living donation.

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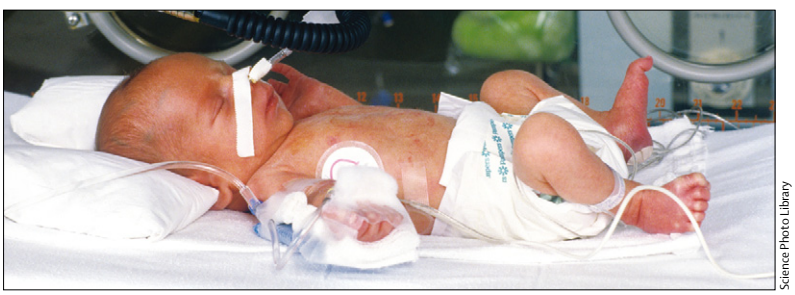
Ban extension Singapore is to extend its public smoking ban, with the long-term goal of total prohibition of smoking in public places apart from in designated smoking areas. The government will expand the ban to cover places such as corridors, staircases, sheltered walkways, and a 5 m radius of bus shelters, and will consider inclusion of some parks.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New surfactant approved A new drug for the prevention of respiratory distress syndrome in premature infants has been approved by the US Food and Drug Administration. Lucinactant is the fifth artificial surfactant approved in the USA to treat this disorder, in which infants cannot make enough surfactant, resulting in lung collapse and difficulty breathing.

Drug development The Wellcome Trust has awarded more than £10 million to the University of Dundee to work collaboratively with GlaxoSmithKline on neglected tropical disease research. The aim is to develop safe and affordable treatments for Chagas disease, leishmaniasis, and sleeping sickness—diseases that cause about 150 000 deaths every year.

Brain prize 2012 The Grete Lundbeck European Brain Research Prize 2012 has been awarded to Christine Petit, of the Institut Pasteur, Paris, France, and Karen Steel of the Wellcome Trust Sanger Institute, Cambridge, UK. The €1 million prize was given in recognition of the researchers' elucidation of "the causes of many of the hundreds of inherited forms of deafness".

Handwashing world record Peru has broken the Guinness World Record for simultaneous handwashing, which was previously held by Bangladesh. Director of the Pan American Health Organization, Mirta Roses Periago, presented the award on March 2, after 604 246 schoolchildren across the country washed hands simultaneously on Global Hand Washing Day last year.

Coordinating success An estimated 910 000 lives have been saved over 6 years by improved coordination between HIV and tuberculosis services, according to WHO. The organisation has released an updated global policy for HIV and tuberculosis, emphasising routine HIV testing for patients with tuberculosis, and provision of co-trimoxazole and antiretroviral therapy for co-infected patients.

***C diff* dilemma** About 75% of health-care-associated *Clostridium difficile* infections in the USA first occur in nursing home residents or in those who have recently visited primary care, with only 25% affecting hospital inpatients, according to the US Centers for Disease Control and Prevention. *C difficile* infections in the USA are at an all-time high, with infections linked to 14 000 deaths every year.

Air pollution control Shanghai, China, is to invest US$1·6 billion in air pollution control, beginning this year. The money will be spread between 53 projects designed to limit emission of particles larger than 2·5 μm in diameter. A quarter of such particles currently come from motor vehicle emissions. Industrial pollution is also cited as a major source, as well as sandstorms from northern China.

Non-contact sports The British Olympic Association has warned athletes against the perils of hand shaking at the London Olympic Games in July. The organisation has emphasised that hand hygiene is paramount during the games to minimise the risk of catching a performance-thwarting illness in the intensely competitive environment of the Olympic Village.

For the **US Surgeon General's report on tobacco use in young people** see http://profiles.nlm.nih.gov/ps/access/NNBCFT.pdf

For more on **access to pain relief in Nigeria** see http://www.treatthepain.com/gapri-press-release-nigeria

For **more on the approval of lucinactant** see http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm294984.htm

For more on **neglected tropical disease research at the University of Dundee** see http://www.dundee.ac.uk/pressreleases/2012/march12/tropicaldisease.htm

For the **Brain Research Prize 2012** see http://www.thebrainprize.org/flx/prize_winners/2012/cc/

For **Peru's world handwashing record** see http://new.paho.org/per/index.php?option=com_content&task=view&id=1686&Itemid=1926

For the **WHO policy on collaborative TB/HIV activities** see http://whqlibdoc.who.int/publications/2012/9789241503006_eng.pdf

For the **CDC report on *Clostridium difficile* infections acquired in hospital** see http://www.cdc.gov/VitalSigns/pdf/2012-03-vitalsigns.pdf


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The health of deaf people: communication breakdown

In their Review on the mental health of deaf people published in *The Lancet* this week, Johannes Fellinger and colleagues write about the social adversity associated with deafness, the high prevalence of depression and anxiety among deaf people, and the barriers they face in accessing mental health services. At the heart of these issues is the problem of communication. In mental health, as in all areas of medicine, good communication is the bedrock of diagnosis and treatment. It is therefore deeply worrying that the evidence suggests communication between deaf patients and health professionals is so poor.

Because of communication problems, deaf people face barriers to health care before they even reach the consultation room. Care pathways are not always joined up: for example, it is difficult in many parts of the UK for deaf patients to access the Improving Access to Psychological Therapies programme or counselling services via primary care. Then there is the matter of arranging an appointment. Without adequate provision of email and text software, deaf patients must spend a great deal of time and effort going to the clinic to book in person. Even when the patient has arrived for the appointment and is sitting in the waiting room, something as simple as indicating when the clinician is free may not be done effectively by reception staff. During the consultation, the difficulties multiply. As Andrew Alexander and colleagues state in their Comment, lip-reading is not reliable, writing notes is inadequate, and British Sign Language (BSL) interpreters are scarce. It is no surprise that in a 2004 UK survey, a third of BSL users reported that they avoided going to see their general practitioner because of communication problems. More than three quarters, meanwhile, stated that they could not communicate easily with hospital staff. Doctors may believe they communicate well with their patients: their patients beg to differ.

Perhaps technology—the use of webcams and online communication or interpreting—will ultimately help with some of these problems. However, the advice given in Fellinger and colleagues' review, including simply allowing sufficient time for the consultation, should prove useful to every clinician, in every specialty, here and now.

There is, however, a still greater challenge in terms of communication with deaf patients that is specific to mental health professionals. For a specialty that focuses on human experience, emotion, and behaviour, psychiatry can sometimes prove surprisingly oblivious to cultural factors. Psychiatrists should not exclusively judge a patient's symptoms against a theoretical norm, but take into account how individual factors may affect their presentation of mental distress. For example, in the diagnosis of schizophrenia, a key symptom is that of auditory hallucinations in the third person or as a running commentary. What is the equivalent experience in a patient who has never been able to hear? Research in this area has revealed much of interest both to the working clinician and to the cognitive neuroscientist. Painstaking work by Joanna Atkinson of University College London—herself a deaf BSL user—has shown how this hallucinatory experience may present as, for example, a mental image of lips moving or hands signing. It is important to know that this possibility exists and to be flexible and responsive to the needs and experiences of the patient. This sort of flexibility must be promoted throughout psychiatric training and, in future, through revalidation. Then there is the matter of communication between the psychiatric profession and the public. Education regarding mental health encourages those who need help to seek it, and assists families and friends in supporting their loved ones. The professionals who work in specialist deaf services have knowledge and experience—about both mental illness and the challenges deaf people face—that are invaluable to the public and to allied health professionals.

Finally, the poor state of communication between the UK Government and medical professionals and patients must be addressed. Deaf patients face the prospect of a fragmented health service under the current Health and Social Care Bill. Fragmented services cause poor communication between agencies, and poor communication damages patient care. If this government continues to ignore the warnings, a Deaf Clinical Network of the kind proposed by SignHealth will be more important than ever. Deaf people have long been denied the services they need. *The Lancet* looks forward to publishing more on the wellbeing of deaf people in future, and hopes to contribute to a new era of better communication and access to health care. ■ *The Lancet*

Wellcome Library, London

See **Comment** page 979

See **Review** page 1037

For more on the **Improving Access to Psychological Therapies programme** see http://www.iapt.nhs.uk

For the **report on deaf and hard of hearing people's experience of the NHS** see http://www.actiononhearingloss.org.uk/~/media/Documents/Research%20and%20policy/Political%20updates/A%20simple%20cure.ashx

For the **UCL Deafness Cognition and Language Research Centre** see http://www.ucl.ac.uk/dcal/

For **SignHealth** see http://www.signhealth.org.uk

For the **British Society for Mental Health and Deafness** see http://www.bsmhd.org.uk

Progress in sanitation needed for neglected tropical diseases

Jacob Silberberg/Panos

On March 22, World Water Day, there is some good news to celebrate. According to a new report, *Progress on Drinking Water and Sanitation 2012*, released by WHO and UNICEF on March 6, part of Millennium Development Goal (MDG) 7—halving the proportion of people without sustainable access to safe drinking water—was met in 2010. 89% of the world's population, or 6·1 billion people, have access to improved drinking water sources, estimated to rise to 92% by 2015. Although there is still unacceptable inequality, this progress is encouraging.

The same cannot be said for the other part of MDG 7—halving the proportion of people without access to basic sanitation. Progress here is shockingly slow. Only 63% of the world's population have access to basic sanitation and the projection for 2015 is 67%, well short of the target of 75%. Even in countries with vastly improved economic outlooks, such as China and Brazil, 14 million and 7·2 million people, respectively, practice open defecation. A quarter of people in the least developed countries have no access to toilets or latrines. Improving sanitation and hygiene is not at the forefront of development aid despite its obvious preventive effects on many infectious diseases, including most neglected tropical diseases.

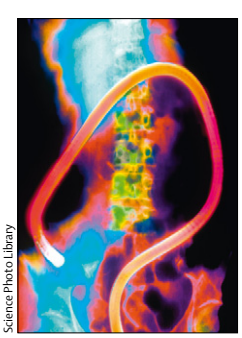
Indeed, at the launch of the WHO roadmap for *Accelerating Work to Overcome the Global Impact of Neglected Tropical Diseases*, discussed earlier this year at a seminal meeting in London, only passing comments to improvement of water and sanitation were made. Out of five recommended strategies, provision of safe water, sanitation, and hygiene came last, almost as an afterthought without urgency or hope for improvement. No specific targets and goals were included in the context of neglected tropical diseases, nor was it clear who from this new partnership will take up this task.

Without attention to this basic right, elimination and certainly eradication of these diseases will remain an unachievable dream. Until sanitation and universal access to toilets and latrines becomes an urgent priority discussed openly and forcefully by all who aim to improve global health, progress will be hampered by our own reluctance to tackle this obvious source of ill-health. ■ *The Lancet*

For ***Progress on Drinking Water and Sanitation 2012*** see http://whqlibdoc.who.int/publications/2012/9789280646320_eng_full_text.pdf

For more on the **WHO NTD roadmap** see http://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf

New guidance for colorectal cancer screening



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"Colorectal cancer screening comes of age", declared Sidney J Winawer, past president of the American College of Gastroenterology, in 1993. Yet after almost two decades, only 61% of the eligible population in the USA gets screened for this common cancer.

To encourage more people to participate in colorectal cancer screening, the American College of Physicians (ACP) issued new guidance on March 6. The statement is based on a critical review of existing guidelines developed by other US organisations including the American Cancer Society. ACP calls for colorectal cancer screening to start at the age of 50 years for people at average risk, and at 40 years (or 10 years before the age of the youngest case of colorectal cancer in a family) for people at high risk. Stool-based tests, flexible sigmoidoscopy, and optical colonoscopy are all acceptable screening options for people at average risk, say ACP, while the gold standard—optical colonoscopy—is recommended for people at high risk.

Although underscreening for colorectal cancer is a problem for some people, so is overscreening. According to the new guidance, screening should be stopped for adults aged over 75 years or who have a life expectancy of less than 10 years. Of note, colorectal cancer screening can lead to harmful outcomes such as perforation, bleeding, and false-negative results. Additionally, sigmoidoscopy or colonoscopy can be unpleasant or embarrassing for many people. Thus, the choice of tests should also take into consideration the risks of screening and people's personal and cultural preferences.

Internationally, there are substantial variations among screening recommendations. For instance, the UK now recommends once-only screening for people aged 55–60 years using flexible sigmoidoscopy and the faecal occult blood test for those aged 60 years and older. The introduction of flexible sigmoidoscopy followed the results of a 2010 trial, which showed that the test conferred substantial and long-lasting benefit. General practitioners, internists, and surgeons should urge eligible people to take part in screening programmes, and such initiatives should always be based on the best evidence. ■ *The Lancet*

For more on **"Colorectal cancer screening comes of age"** see http://www.nejm.org/doi/full/10.1056/NEJM199305133281909/

For more on **ACP guidance statement** see http://www.annals.org/content/156/5/378.abstract

For the **UK recommendations** see http://www.cancerscreening.nhs.uk/bowel/index.html

For the **2010 trial** see **Articles** *Lancet* 2010; **375:** 1624–33

Deafness might damage your health

See **Editorial** page 977
See **Review** page 1037
For a **BSL translation of this Comment** see webvideo

One in seven people in the UK are deaf, most of whom are hard of hearing.[1] About 70 000 of these individuals are profoundly deaf, either from birth or before acquiring speech. Most communicate through British Sign Language (BSL) as their first or preferred language, rather than spoken English. These individuals together form the Deaf community, with their own language, culture, and history.[2]

People from the Deaf community encounter many barriers in the health-care system and often have bad experiences, usually because of poor communication. Most health-care workers have little experience of sign-language users because few are in the public eye or are health-care professionals. Ignorance leads to negative attitudes, and patients from the Deaf community endure both individual and institutional discrimination.[1] Clinicians regarding BSL users as disabled come across as patronising,[3] and entries are still seen in patients' medical records stating that a full history has not been taken because the patient is deaf.

In *The Lancet*, Johannes Fellinger and colleagues[4] review the extensive evidence of mental health problems in deaf people, which are substantially more common than in hearing populations. Many anecdotes of poorer physical health in people from the Deaf community exist, but there are no robust studies. Research is needed to establish whether people from the Deaf community have poorer health than do hearing individuals, and to explore underlying causes.

Poor communication in a consultation can lead to medical error. Reliance on lip-reading is inadequate, because lip-readers understand only part of a conversation and use guesswork to fill gaps. Communicating through a series of handwritten notes is an unsatisfactory substitute for a full consultation, not least because people from the Deaf community have often had poor-quality education, and many have lower-than-average literacy.

A qualified interpreter should be present in a consultation between a clinician and a patient who uses BSL to enable full communication for both professional and patient. Without an interpreter, the clinician cannot make an adequate clinical assessment or explain the diagnosis and treatment, and the patient is denied the opportunity to discuss his or her concerns. However, interpreters are scarce and advance booking is necessary, so they are often unavailable for appointments with family doctors or for emergencies. Therefore, patients frequently rely on family or friends to interpret, but few are qualified interpreters, and patients' autonomy and privacy are compromised. Online access to interpreters via computers and webcams has improved availability, particularly at short notice. Some services now provide 24 h cover.

A UK survey[5] showed that 77% of BSL users had difficulty communicating with hospital staff. 33% left consultations with their family doctor unsure about medication instructions or subsequently took the wrong doses. Reeves and colleagues[6] reported that BSL interpreters were present at 17% of consultations with a family doctor and 7% of those in hospital emergency departments. The study showed that people from the Deaf community have substantially poorer access to primary care and emergency services, and have difficulties at all stages of the health-care process. The main causes were poor deaf awareness of doctors, nurses, and reception staff, and insufficient provision of interpreters. Nevertheless, 87% of family doctors feel that they can communicate effectively with their hard-of-hearing patients and those who use BSL.[7] Most worryingly, however, 30% of BSL users avoid seeing their family doctor because of communication difficulties, thereby risking their health rather than facing another struggle with the health-care system.[5]

Anita Houlding, Royal United Hospital, Bath

Andrew Alexander consults with Paddy Ladd (left) via Pascale Maroney, a BSL/English interpreter

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